AD-A192 888 MEDICARE: PERFORMANCE OF BLUE SHIELD OF MASSACHUSETTS UNDER THE TRI-STATE CONTRACT(U) GENERAL ACCOUNTING OFFICE WASHINGTON DC HUMAN RESOURCES DIV MAR 88 1/1

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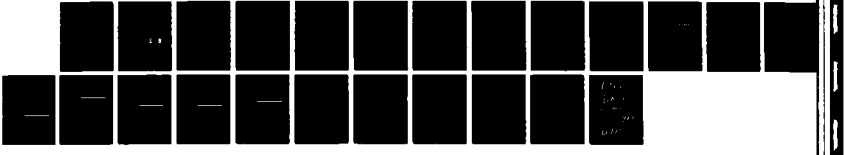

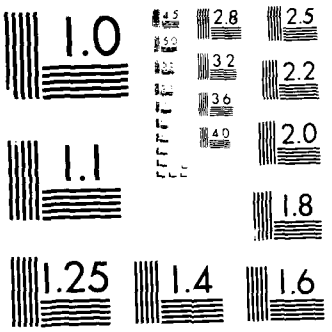

United States General Accounting Office

GAO

Briefing Report to Congressional Requesters

March 1988

MEDICARE

Performance of Blue Shield of Massachusetts Under the Tri-State Contract

GAO/HRD-88-81BR

GAO

United States
General Accounting Office

Boston Regional Office

10 Causeway Street, Room 575
Boston, MA 02222

B-230510

March 31, 1988

The Honorable Gordon J. Humphrey
The Honorable Warren B. Rudman
The Honorable Robert T. Stafford
The Honorable Patrick J. Leahy
The Honorable William S. Cohen
The Honorable George J. Mitchell
United States Senate

The Honorable Judd A. Gregg
The Honorable Robert C. Smith
The Honorable James M. Jeffords
The Honorable Olympia J. Snowe
The Honorable Joseph E. Brennan
House of Representatives

Letters to us dated December 18, 1986, and January 21 and April 24, 1987, from the New Hampshire, Vermont, and Maine congressional delegations, respectively, cited numerous beneficiary and provider complaints relating to the quality of Medicare services. In these letters you asked us to review the performance of Blue Shield of Massachusetts as the Medicare Part B carrier for those three states. As agreed with your offices, we compared Blue Shield's performance with certain contract requirements for six areas: timeliness of claims payment, payment accuracy, telephone service, reviews of denied claims, responses to written inquiries, and requests for information already provided.

Based on Blue Shield information, evaluations by the Health Care Financing Administration (HCFA), and our own observations, we reported preliminary results to you in our May 1987 briefings and our June 5, 1987, letter. At the same time, we agreed to monitor Blue Shield's performance through December 1987 and to test the reliability of certain Blue Shield data. On January 25-27, 1988, we briefed your offices on the final results of our work. This briefing report presents these results in more detail.

We did our work at Blue Shield's corporate offices in Boston, Massachusetts, and at its Medicare Part B tri-state claims processing center in Biddeford, Maine. We also performed work at HCFA's regional office in Boston. We analyzed Blue Shield

reports showing its performance under the tri-state contract and examined HCFA's evaluations of Blue Shield's performance. We also performed tests to validate certain data that Blue Shield reports to HCFA.

Although Blue Shield did not meet several contract requirements during the initial year (fiscal year 1986), our review disclosed its performance has since improved significantly.

Blue Shield's Performance,
Fiscal Years 1986 and 1987

Areas of concern	Did Blue Shield meet contract requirements related to areas of concern? Fiscal year 1986	1987
Claims processing:		
Timeliness	Yes	Yes
Acceptable inventory levels	No	Yes
Accuracy of claims payments	No	Yes
Telephone service:		
Accessibility of beneficiary lines	No	Yes
Accessibility of provider lines	[a]	Yes[b]
Timely answering of beneficiary calls	[a]	No
Timely reviews of denied claims	No	Yes
Timely response to written inquiries	No	Yes
Requests for information already provided	Yes	Yes

[a]HCFA did not measure performance.

[b]HCFA did not measure performance, but we found that Blue Shield was in compliance for at least 7 of the last 8 months of calendar year 1987.

For fiscal year 1987, Blue Shield was in compliance with all but one of the contract requirements relating to the six areas. The one requirement not met was that 95 percent of beneficiary calls be answered by a Blue Shield representative either immediately or within 120 seconds after being placed on hold and the recorded message begins. Blue Shield, in an effort to meet this requirement, provided HCFA with a corrective action plan on February 9, 1988 (see p. 15).

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As requested, we did not obtain formal agency comments on this report. However, we did discuss its contents with HCFA and Massachusetts Blue Shield officials and have incorporated their comments where appropriate. Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the issuance date. At that time, we will send copies to congressional committees having jurisdiction over matters discussed in the report, the Secretary of Health and Human Services, and other interested parties.

Should you have any questions regarding this report, please call me on (617) 565-7555.

Sincerely yours,

Morton A. Myers

Morton A. Myers
Regional Manager

CONTENTS

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration

MEDICARE: PERFORMANCE OF BLUE SHIELD OF MASSACHUSETTS UNDER THE TRI-STATE CONTRACT

BACKGROUND

Medicare is a federal health insurance program for eligible people age 65 or older and certain disabled individuals. Medicare was established by title XVIII of the Social Security Act (42 U.S.C. 1395) and became effective on July 1, 1966. The program provides two basic forms of protection:

-- Hospital Insurance (Part A) covers inpatient hospital services, posthospital care in skilled nursing facilities, home health care, and hospice care.

-- Supplementary Medical Insurance (Part B) covers physician services, outpatient hospital services,[1] and other services and supplies.

Within the Department of Health and Human Services, the Health Care Financing Administration (HCFA) is responsible for the Medicare program, including establishing regulations and policies under which the program operates. HCFA contracts with insurance companies to process and pay Medicare claims. Companies that process and pay Part B claims are called carriers.

On April 19, 1985, HCFA awarded a fixed-price contract (commonly referred to as the tri-state contract) to Blue Shield of Massachusetts to serve as the carrier responsible for processing Medicare Part B claims from the states of Maine, New Hampshire, and Vermont. The contract runs for 3 years from October 1, 1985, to September 30, 1988. With Blue Shield's agreement, HCFA can renew the contract, at a renegotiated price, for up to two separate 1-year extensions. HCFA must give Blue Shield written notice of its intention to renew the contract at least 180 days before the contract ends.

Blue Shield is currently in the third year of its contract. Table 1 presents the number of claims processed and the amount of Medicare benefits paid under this contract for fiscal years 1986 and 1987.

Table 1: Claims Processed and Benefits Paid

	Fiscal years	
	1986	1987
Claims Processed	3,302,926	3,783,116
Benefits Paid	$141,706,121	$171,924,870

[1]Although outpatient hospital services are a Part B benefit, claims are processed by Part A contractors, known as fiscal intermediaries.

OBJECTIVES, SCOPE, AND METHODOLOGY

In separate letters, the New Hampshire, Vermont, and Maine congressional delegations cited numerous beneficiary and provider complaints about Medicare program services in their states and asked that we review Blue Shield's performance in six areas:

-- Claims payment timeliness.

-- Payment accuracy.

-- Telephone service.

-- Reviews of denied claims.

-- Responses to written inquiries.

-- Requests for information already provided.

We agreed with the staffs of the delegations to provide a status report on Blue Shield's performance in these six areas by comparing Blue Shield's performance to certain contract requirements. We reported our preliminary results, based on Blue Shield information, HCFA evaluations, and our own observations, in our May 1987 briefings and our June 5, 1987, letter to the congressional delegations. On January 25-27, 1988, we briefed staff of the delegations on the final results of our work. This briefing report presents the results of our January 1988 briefing in greater detail.

We met with Blue Shield officials in Boston and at Blue Shield's Medicare Part B tri-state claims processing center in Biddeford, Maine. We reviewed Blue Shield reports concerning claims processing and telephone service, and HCFA reports on Blue Shield payment errors. We also reviewed segments of HCFA's fiscal years 1986 and 1987 evaluations of the tri-state contract relating to the six areas noted above. We held discussions with HCFA officials in Boston on their evaluation results and the methodology they used to perform these studies.

To determine if Blue Shield complied with the contract requirements for claims processing timeliness, we reviewed the appropriate sections of the tri-state contract. After obtaining and examining Blue Shield reports on claims processing times, we discussed these with Blue Shield officials. We then compared Blue Shield performance to contract requirements. Because the information on claims processing times originates with Blue Shield's reports, we undertook a two-stage process to verify its accuracy. Appendix I describes the methodology we used.

To determine if Blue Shield met contract requirements on the accuracy of claims payments, we reviewed appropriate sections of the tri-state contract and HCFA reports on payment accuracy. We discussed the HCFA methodology used to prepare the reports with HCFA officials. We then compared Blue Shield performance to contract requirements.

With respect to contract requirements for telephone service, we reviewed appropriate sections of the tri-state contract and Blue Shield reports on such services. We discussed these reports with Blue Shield officials and, on a test basis, verified Blue Shield's analysis of provider and beneficiary telephone service data. We then compared Blue Shield performance to contract requirements.

To determine if Blue Shield met contract requirements for the timely processing of (1) reviews of denied claims and (2) responses to written inquiries, we reviewed appropriate sections of the tri-state contract and related segments of HCFA's annual evaluations of Blue Shield's performance for fiscal years 1986 and 1987. We discussed these evaluations and HCFA's methodology for measuring compliance with HCFA officials. We then compared Blue Shield performance to contract requirements.

Concerning the allegation of reported requests by Blue Shield for information already provided, we reviewed the contract and found one requirement, for the controlling (locating) of claims, that partially relates to this issue. We tracked a statistically valid random sample of provider claims, as described in appendix I, to determine whether Blue Shield was losing claims, which could lead to requests for information already provided.

Our work was conducted from February through December 1987. As requested, we did not obtain agency comments on this briefing report. However, we discussed its contents with HCFA and Blue Shield officials and have incorporated their comments where appropriate. Our work was performed in accordance with generally accepted government auditing standards.

STATUS OF BLUE SHIELD'S PERFORMANCE IN EACH OF THE SIX AREAS

For the initial contract year (fiscal year 1986), HCFA determined that Blue Shield did not meet several contract requirements relating to the six areas under review. Since then, Blue Shield's performance has improved significantly. For fiscal year 1987, Blue Shield was in compliance with all contract requirements but one relating to these areas. Appendix II compares Blue Shield's performance for fiscal years 1986 and 1987 in the six areas with related contract requirements.

While we did not attempt to identify the causes of earlier problems, we did note that the number of Blue Shield employees working on the tri-state contract increased substantially. For example, December 1987 staffing levels reflect (1) a 76-percent increase over the level proposed by Blue Shield in its response to HCFA's request for proposal, and (2) a 60-percent increase over Blue Shield's actual staffing levels when the contract became operational on October 1, 1985. We believe this increase contributed to Blue Shield's improved performance, even though part of the increased staff may have been needed due to a growth in claims volume.

Timeliness of Claims Payment

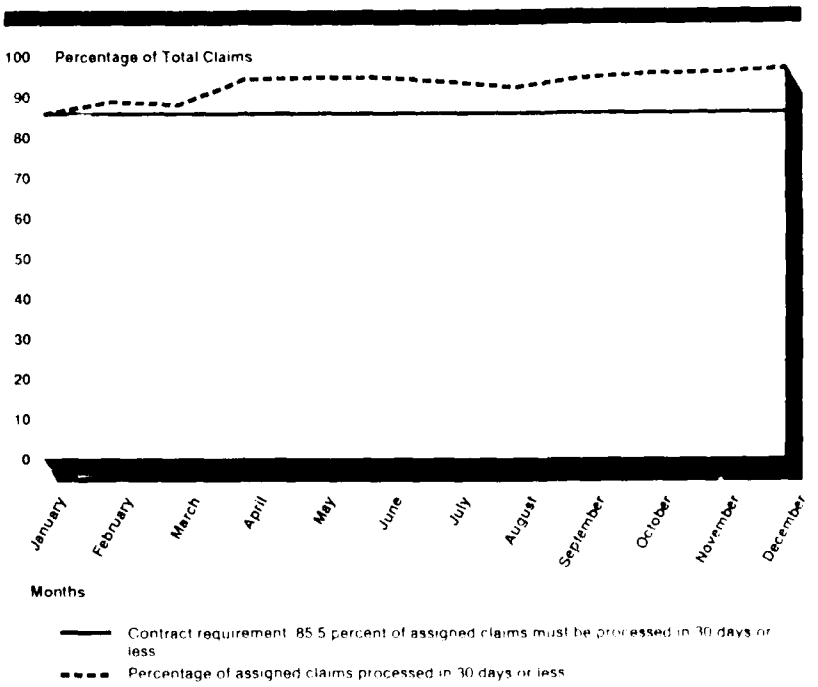
Since experiencing claims processing delays during the initial contract year, Blue Shield has improved its performance. As of December 31, 1987, Blue Shield was in compliance with all claims processing timeliness requirements.

Three contract requirements relate to timely claims processing:

1. Of all assigned claims (those paid directly to providers), 85.5 percent must be processed in 30 days or less.[2] HCFA's fiscal years 1986 and 1987 evaluations of the contract showed that Blue Shield complied with this requirement during both evaluation periods by processing 88.1 and 89.4 percent, respectively, of the assigned claims in 30 days or less. Blue Shield's monthly reports for calendar year 1987 show that Blue Shield met the 85.5-percent requirement each month, with performance ranging from a low of 85.5 percent in January to a high of 96.3 percent in December (see figure 1).

[2]Processing time is measured from when Blue Shield receives a claim to when Blue Shield decides to pay or deny it.

Figure 1: Assigned Claims Processed in 30 Days or Less (Calendar Year 1987)



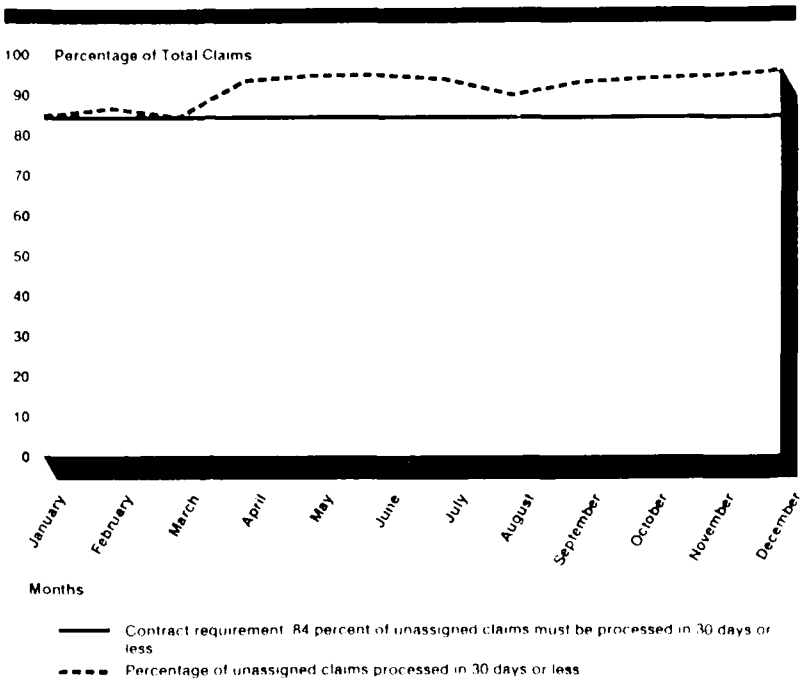
We verified Blue Shield's reported claims processing times for assigned claims by comparing estimated processing times from our sample with the data Blue Shield reported for its entire workload of assigned claims during the months in which the sample claims were processed. Based on our sample results, we estimate that 97.48 percent of all assigned claims that providers[3] submitted to Blue Shield during that period were processed in 30 days or less. And, we are 95 percent confident that the true percentage of claims processed within 30 days falls between 96.1 and 98.8 percent. Most of the claims in our sample were processed during the period September through November 1987. By comparison, Blue Shield reported that 94.9 percent of the assigned claims it processed in the months of September, October, and November 1987 were processed within 30 days.

2. Of all unassigned claims (those to be paid directly to beneficiaries), 84 percent must be processed in 30 days or less. HCFA's fiscal years 1986 and 1987 evaluations of the contract showed that Blue Shield complied with this requirement during both evaluation periods by processing 88.7 and 89.4 percent, respectively, of unassigned claims in 30 days or less. According to Blue Shield's monthly reports for calendar year 1987, it met the 84-percent requirement each month with performance ranging from a low of 84.1 percent in March to a high of 95.4 percent in

[3]These providers submitted 99 percent of all assigned claims to Blue Shield during calendar year 1986.

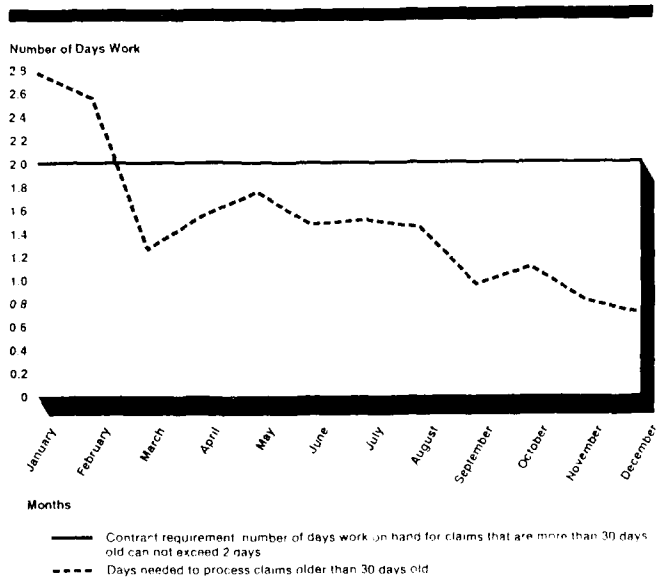
December (see figure 2). Our tests of Blue Shield's internal reporting system for December 1986, showed that Blue Shield's reports accurately summarized the claims processing information contained in its system.

Figure 2: Unassigned Claims Processed in 30 Days or Less (Calendar Year 1987)



3. The time needed to process the inventory of claims older than 30 days cannot exceed 2 days. According to HCFA's fiscal year 1986 evaluation of the contract, Blue Shield had a monthly average of 4.1 days of processing effort and thus did not comply with this requirement during the evaluation period. But, according to HCFA's fiscal year 1987 evaluation, Blue Shield was in compliance with a monthly average of 1.7 days of processing effort. Information for calendar year 1987 shows that while Blue Shield did not meet the 2-day contract requirement for January and February 1987, it did meet the requirement for the remainder of the year (see figure 3).

Figure 3: Number of Days Needed to Process the Inventory of Claims Older than 30 Days (Calendar Year 1987)



Payment Accuracy

Blue Shield did not meet the contract requirements concerning claims payment accuracy during the first year of the contract. Since then, its performance has improved and, as of December 31, 1987, it was within the error rate limits specified in the contract.

Two contract requirements relate to the accuracy of claims payments: First, the total overpayment error amount for a fiscal year must not exceed $1.20 for every $100 of submitted charges, the amount billed by providers, for claims processed. Second, the total underpayment error amount for a fiscal year must not exceed $0.70 for every $100 of submitted charges for claims processed. HCFA measures contractor performance in these areas by developing overpayment and underpayment error rate ratios.

On a weekly basis, Blue Shield, using HCFA's computerized sampling plan, randomly selects a sample of processed claims based on claims volume. Blue Shield reviews the sample claims and supporting documentation to identify payments that are above or below the amount allowed by Medicare. Using the same HCFA sampling plan, Blue Shield randomly selects a subsample of claims from its original sample and forwards these claims and supporting documentation to HCFA. HCFA reviews the claims subsample and documentation to identify overpayments and underpayments. After completing separate reviews, HCFA and Blue Shield meet to resolve any differences concerning errors detected in the subsample.

HCFA then revises Blue Shield's original sample results to reflect the subsample findings and calculates the final monthly overpayment and underpayment error rates. Compliance with the contract terms is based on the yearly average of these rates.

Blue Shield had a $3.20 overpayment error rate and a $1.79 underpayment error rate, according to HCFA's fiscal year 1986 evaluation of the contract. In both cases, Blue Shield did not meet the contract requirements. HCFA's fiscal year 1987 evaluation, however, showed that Blue Shield reduced its overpayment rate to $0.92 and its underpayment rate to $0.68, bringing it into compliance with the contract. In calendar year 1987, Blue Shield did not exceed the $1.20 overpayment rate for any of the 12 months (see figure 4) and exceeded the $0.70 underpayment error rate in only 2 of the 12 months (see figure 5).

Figure 4: Overpayment Dollar Error Rate per $100 of Submitted Charges on Claims Processed (Calendar Year 1987)

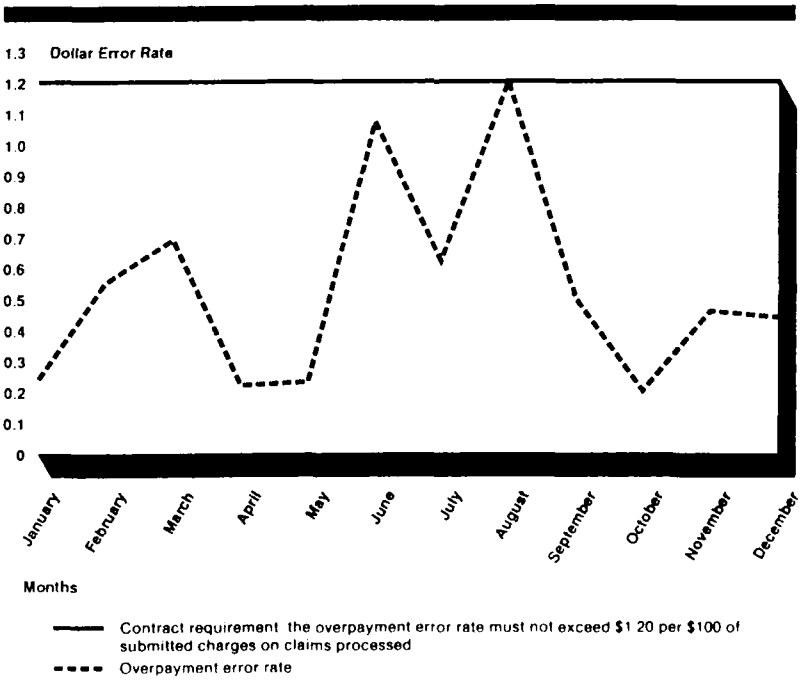
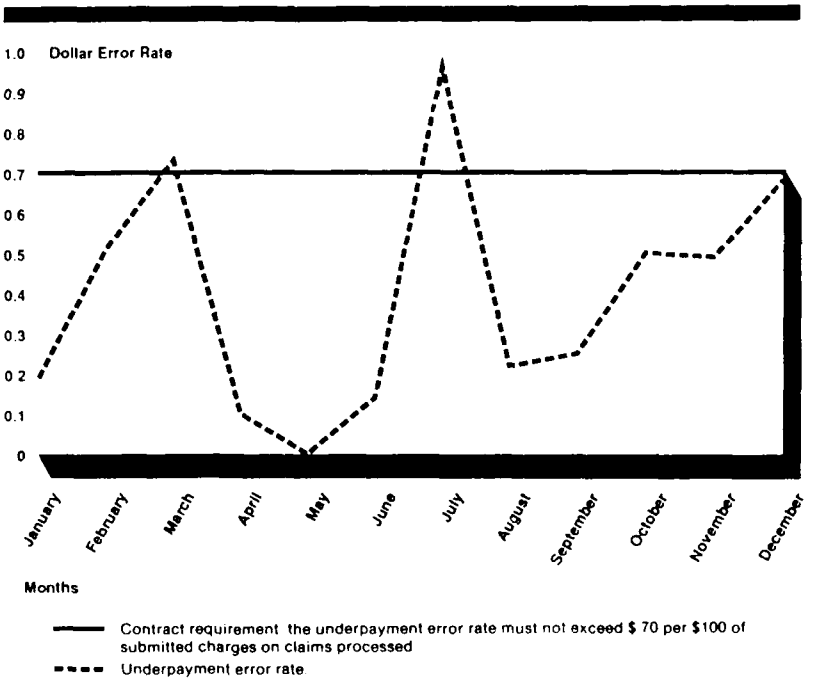


Figure 5: Underpayment Dollar Error Rate per $100 of Submitted Charges on Claims Processed (Calendar Year 1987)



Telephone Service

Under the tri-state contract, Blue Shield must provide toll-free telephone service to both beneficiaries and providers. Blue Shield experienced telephone service problems during the initial contract year. As of December 31, 1987, Blue Shield's monthly reports to HCFA indicated that performance had improved, but problems still existed in one service area.

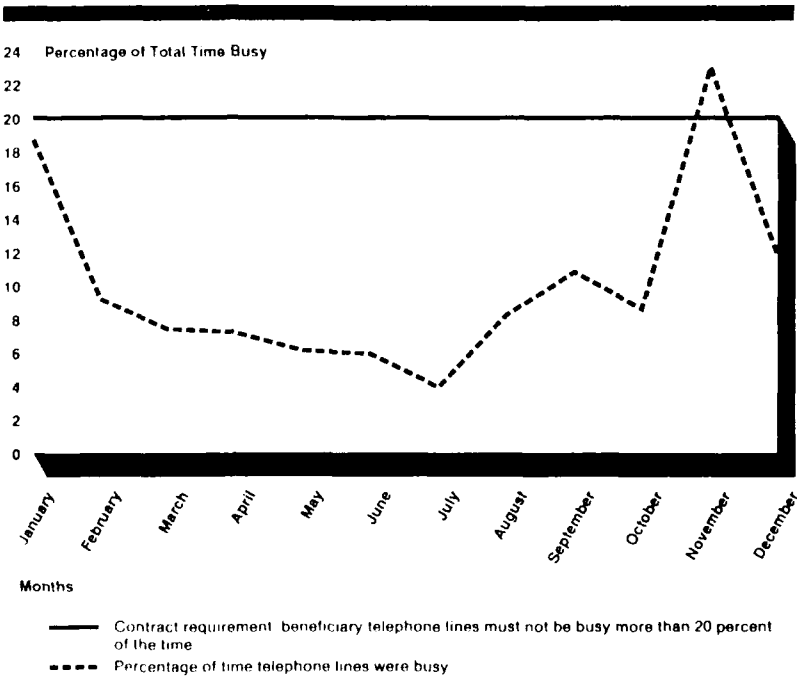
The information that Blue Shield uses to develop its monthly performance statistics for telephone services originates from a telephone monitoring device. It records data on such telephone activity as the total time that all lines are busy, the number of calls not answered within 120 seconds, and the total number of calls Blue Shield receives. Using this information, Blue Shield computes the busy-signal rates and telephone-answering times, which appear in its monthly reports to HCFA. Although we did not verify the accuracy of the machine-generated information, we did verify Blue Shield's computations, on a test basis, and found them generally accurate.

Three contract requirements relate to the quality of telephone service:

1. Blue Shield's telephone lines for beneficiaries must not be busy more than 20 percent of the time. Blue Shield did not comply with this requirement during fiscal year 1986, according to HCFA's evaluation of its contract performance. Telephone

lines were busy 26 percent of the time. HCFA's fiscal year 1987 evaluation, however, showed that Blue Shield was in compliance. Blue Shield did not exceed the 20-percent limit in any month during the evaluation period. Blue Shield's monthly reports for calendar year 1987 show that it did not exceed the 20-percent limit during the year except in November (see figure 6).

Figure 6: Percentage of Time Blue Shield's Telephone Lines for Beneficiaries Were Busy (Calendar Year 1987)



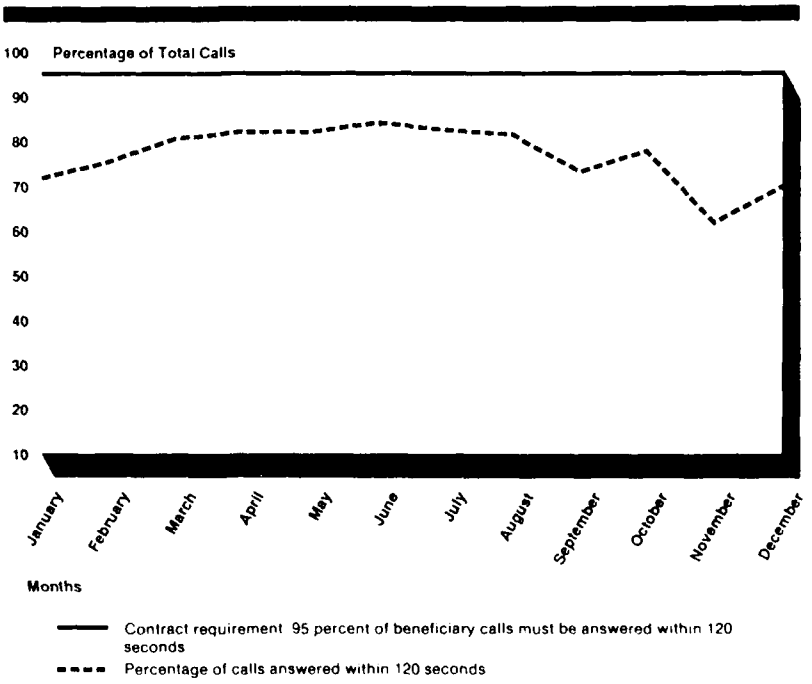
According to a Blue Shield official, the 20-percent requirement was not met in November partially because of a significantly increased number of telephone calls. The increased volume of calls resulted from concerns that benefit payments would be reduced due to proposed federal budget cuts, the official said. Our analysis of Blue Shield telephone data confirmed that there was about a 20-percent increase in calls per day during November compared with the daily average for September, October, and December 1987.

2. Blue Shield representatives must answer 95 percent of beneficiary telephone calls within 120 seconds.[4] During its fiscal year 1986 evaluation of the contract, HCFA did not review Blue Shield's performance for this requirement. HCFA's central office waived this requirement for all carriers because the necessary equipment for measuring performance was not available. Starting January 1, 1987, Blue Shield had the needed equipment in

[4]If a call is not answered immediately, the 120-second requirement is calculated from the start of the recorded message.

place to record performance in this area, and HCFA's fiscal year 1987 evaluation disclosed that Blue Shield was not in compliance during the review period. Blue Shield representatives answered 79.1 percent of the beneficiary calls within 120 seconds. Furthermore, Blue Shield's monthly reports for calendar year 1987 show that Blue Shield failed to meet this contract requirement in each of the 12 months (see figure 7).

Figure 7: Percentage of Beneficiary Calls Answered Within 120 Seconds (Calendar Year 1987)

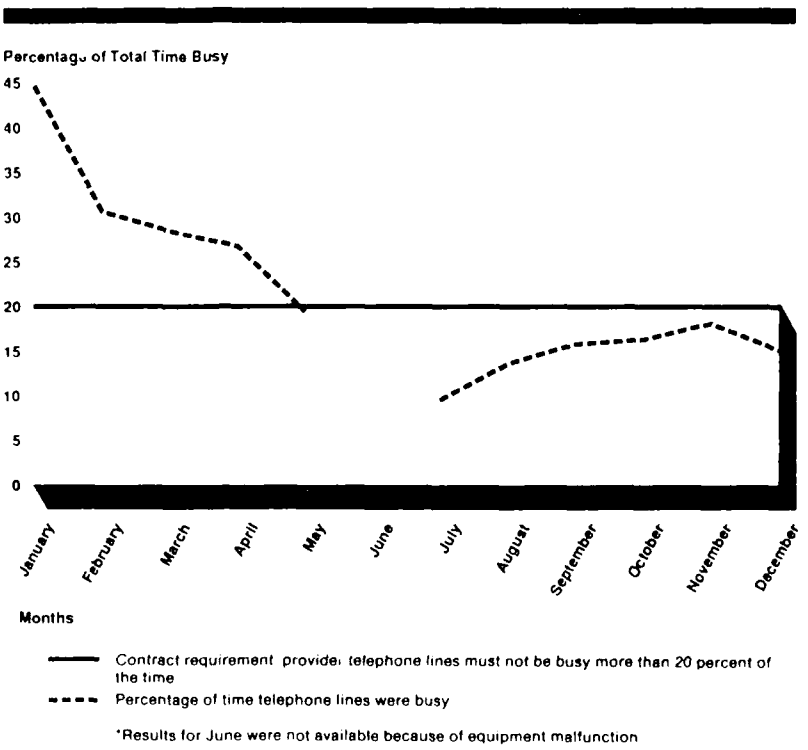


At the completion of its fiscal year 1987 evaluation, HCFA requested that Blue Shield develop a corrective action plan that would bring it into compliance with the 120-second requirement. On February 9, 1988, Blue Shield submitted the requested plan to HCFA. The plan specifies several steps that Blue Shield will take to meet the contract requirement that beneficiary calls be answered within 120 seconds. Through the use of a questionnaire, Blue Shield intends to contact all other carriers to determine how they are organized to provide telephone service and identify the types of telephone and monitoring equipment used. Blue Shield will then develop options and implement changes to improve service and notify HCFA of the results.

3. Blue Shield's telephone lines for providers must not be busy more than 20 percent of the time. As part of its annual evaluation, HCFA does not measure performance in this area. But, information from Blue Shield's monthly reports for calendar year 1987 showed that during the first 4 months of the year, Blue Shield did not meet this contract requirement. From May 1987

through December 1987, however, Blue Shield was in compliance[5] (see figure 8).

Figure 8: Percentage of Time Blue Shield's Telephone Lines for Providers Were Busy (Calendar Year 1987)



Reviews of Denied Claims

When beneficiaries or providers disagree with Blue Shield's claim decisions, either the amount paid or the services covered, they can ask that Blue Shield review its original determination. In the first year of the tri-state contract, Blue Shield did not complete these reviews in accordance with the contract's time requirements. In the second year, however, Blue Shield was in compliance with the contract.

The tri-state contract requires that 95 percent of all requests for reviews of denied claims, also called informal reviews, be completed within 45 calendar days of receipt. HCFA's fiscal year 1986 evaluation showed that by completing only 88.1 percent of the review requests on time, Blue Shield failed to meet this requirement. But, HCFA's fiscal year 1987 evaluation showed that Blue Shield exceeded this requirement by completing 98.3 percent of review requests within the 45 days.

[5]Results were not available for June because of a Blue Shield equipment malfunction.

Unlike the areas of claims processing and telephone service, Blue Shield does not have information on the timeliness of reviews of denied claims. Consequently, we relied on HCFA's evaluation results. HCFA selects a random sample of completed review requests from Blue Shield's files to measure the response time. HCFA compares the date that Blue Shield stamped on each informal review request with the date that Blue Shield completed the review. HCFA then calculates the number of days elapsed from receipt to completion.

Responses to Written Inquiries

Beneficiaries and providers can write to Blue Shield regarding the status of their claims. During the initial contract year, Blue Shield did not respond to these inquiries within the time specified in the contract. But, according to HCFA's last evaluation, Blue Shield came into compliance.

The contract requires that Blue Shield respond to 95 percent of all (1) beneficiary and (2) provider inquiries within 30 calendar days of receipt. Blue Shield failed to meet these requirements, according to HCFA's fiscal year 1986 evaluation. HCFA reported that 74.4 percent of beneficiary inquiries and 83.7 percent of provider inquiries were answered within 30 days. In its fiscal year 1987 evaluation, HCFA reported that Blue Shield answered 100 percent of beneficiary and provider inquiries within 30 days.

As with informal reviews, Blue Shield does not have information on answering beneficiary and provider inquiries. Consequently, we did not independently evaluate Blue Shield's performance in these two areas but relied on HCFA's evaluation results. HCFA selects a random sample of completed inquiries from Blue Shield's files to measure the timeliness of its response. The date stamped on the inquiry by Blue Shield is compared with the date it responded. HCFA then calculates the number of days elapsed from receipt to response.

Requests for Information Already Provided

The tri-state contract does not specifically address performance in this area. However, one contract provision requires Blue Shield to be able to locate a minimum of 97.5 percent of all claims received. Compliance with this requirement should help minimize requests for information already provided. During the fiscal years 1986 and 1987 evaluations, Blue Shield complied with this contract requirement because HCFA located 100 percent and 99.2 percent of the claims, respectively.

To verify that Blue Shield does not lose claims and therefore does not need to request beneficiaries or providers to

resubmit them, we conducted our own sampling effort. Of the 977 claims in our sample, we located 975 claims (99.8 percent). The percentage of claims we located complies with the 97.5-percent contract requirement. We did not project the number of lost claims in our sample to the universe of claims submitted during the 30-day period of our sampling effort because of the small number (2) of sample claims that were lost.

METHODOLOGY TO VERIFY ACCURACY OF CLAIMS PROCESSING TIMES

The information on claims processing times comes from Blue Shield reports. To verify the accuracy of this information, we conducted a two-stage verification process. First, we tested Blue Shield's internal reporting system to determine if its reports accurately summarize claims processing times. We determined how Blue Shield's subcontractor, Electronic Data Systems, develops Blue Shield's reported statistics on timeliness. To determine if we could replicate Blue Shield's reported results, we wrote our own computer program to calculate claims processing times for December 1986. Second, we identified the universe of Medicare providers who accepted assignment, i.e., payment from Medicare rather than the beneficiary, and submitted 50 or more claims to Blue Shield during calendar year 1986. This universe consisted of 2,660 providers who submitted about 99 percent of all assigned claims for the year. We contacted a statistically valid random sample of 75 providers including 15 alternates in the tri-state area and asked them to send us copies of all their assigned claims for the 30-day period from September 14 through October 13, 1987, as they submitted the original claims to Blue Shield. A total of 56 providers participated in our sampling effort. We have no reason to believe that there are any significant differences between participants and nonparticipants based on the reasons given by those who did not participate.

Our sample of 56 providers submitted 5,320 claims to us during the 30-day period under review. From the 56 providers, we selected (1) all the claims submitted during the 30-day period if the provider submitted 20 or fewer claims and (2) a 20-claim random sample if the provider submitted more than 20 claims during the period. Using this method, our sample totaled 977 claims. We used Blue Shield's computer terminals to determine (1) if the claims were entered into Blue Shield's claims processing system, and (2) for claims that were entered, how many were processed in 30 days or less from the time that Blue Shield received them.

APPENDIX II

COMPARISON OF BLUE SHIELD'S PERFORMANCE AS DETERMINED BY HCFA IN THE SIX AREAS WITH RELATED CONTRACT REQUIREMENTS

Related Contract Requirements	Performance Results Fiscal Years 1986	1987
(1) Claims payment timeliness		
85.5 percent of assigned claims must be processed in 30 days or less	88.1%	89.4%
84.0 percent of unassigned claims must be processed in 30 days or less	88.7%	89.4%
Time needed to process claims older than 30 days must not exceed 2 days	4.1 days	1.7 days
(2) Payment accuracy		
The overpayment error rate must not exceed $1.20 per $100 of submitted charges on claims processed	$3.20	$0.92
The underpayment error rate must not exceed $0.70 per $100 of submitted charges on claims processed	$1.79	$0.68
(3) Telephone service		
Telephone lines for beneficiaries must not be busy more than 20 percent of the time	26.0%	<20.0%[a]
95 percent of beneficiary calls must be answered within 120 seconds	—[b]	79.1%
Telephone lines for providers must not be busy more than 20 percent of the time[c]	—	—

APPENDIX II

Related Contract Requirements	Performance Results Fiscal Years 1986	1987
(4) Reviews of denied claims		
95 percent of all reviews must be completed within 45 calendar days of receipt	88.1%	98.3%
(5) Response to written inquiries		
95 percent of all beneficiary inquiries must be answered within 30 calendar days of receipt	74.4%	100.0%
95 percent of all provider inquiries must be answered within 30 calendar days of receipt	83.7%	100.0%
(6) Requests for information already provided		
Blue Shield must be able to locate 97.5 percent of all claims received.	100.0%	99.2%

[a]Blue Shield did not exceed the 20-percent requirement in any month during HCFA's fiscal year 1987 review period.

[b]HCFA waived this requirement during the fiscal year 1986 evaluation for all carriers.

[c]Although HCFA does not measure performance in this area during its annual evaluations, information available from Blue Shield for calendar year 1987 shows that during the first 4 months Blue Shield did not meet the requirement but did meet it for 7 of the last 8 months. During June 1987 Blue Shield was unable to develop the information because of an equipment malfunction.

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processed. HCFA measures contractor performance in these areas by developing overpayment and underpayment error rate ratios.

On a weekly basis, Blue Shield, using HCFA's computerized sampling plan, randomly selects a sample of processed claims based on claims volume. Blue Shield reviews the sample claims and supporting documentation to identify payments that are above or below the amount allowed by Medicare. Using the same HCFA sampling plan, Blue Shield randomly selects a subsample of claims from its original sample and forwards these claims and supporting documentation to HCFA. HCFA reviews the claims subsample and documentation to identify overpayments and underpayments. After completing separate reviews, HCFA and Blue Shield meet to resolve any differences concerning errors detected in the subsample.